Union Workers Benefit Trust
Group #6606

DELTA DENTAL

Effective October 1, 2022

Your Northeast Delta Dental program includes all of the following coverage categories. This chart is provided for summary purposes only. Please refer to your benefit booklet for complete benefit information. In the event of a conflict or discrepancy between this chart and either the group contract or the benefit booklet, the contract or benefit booklet will prevail.

Type	Diagnostic & Preventive (Referred to as Coverage A)	Basic Restorative (Referred to as Coverage B)	Major Restorative (Referred to as Coverage C)	Orthodontics (Referred to as Coverage D)
Covered Services	**DIAGNOSTIC:** Oral evaluations twice per calendar year, this includes periodic, limited, problem-focused, and comprehensive evaluations X-rays (complete series or panoramic film) once in a 5-year period. Bitewing x-rays once in a calendar year. X-rays of individual teeth as necessary Brush biopsy once in a 12-month period **PREVENTIVE:** Four cleanings in a calendar year. These may be any combination of routine or periodontal Fluoride twice in a calendar year to age 19 Space maintainers to age 16 Sealant application to permanent molars, once in a 3-year period per tooth, for children to age 19 Harmful habit appliances **EMERGENCY PALLIATIVE TREATMENT**	**RESTORATIVE:** Amalgam and composite fillings **ORAL SURGERY:** Surgical and routine extractions **ENDODONTICS:** Root canal therapy **PERIODONTICS:** Treatment of gum disease **DENTURE REPAIR:** Repair of removable denture to its original condition	**PROSTHODONTICS:** Removable and fixed partial dentures (bridge); complete dentures Rebase and reline (dentures) Crowns Inlays Onlays Dental Implants	**ORTHODONTICS:** Correction of malposed (crooked) teeth for adults and dependent children
Waiting Period	**See Below**	**See Below**	**See Below**	**See Below**
Deductible	**No Deductible**	**$50/$150 Deductible Per Calendar Year, (January 1 – December 31), Per Person/Family**		**No Deductible**
Coinsurance	**Delta Dental Pays 100%**	***After waiting period and deductible, Delta Dental pays 80%**	***After waiting period and deductible, Delta Dental pays 50%**	**After waiting period, Delta Dental pays 50%**
Maximum	**Coverage A, B and C *Combined* Calendar Year Maximum (January 1 through December 31): $1,500 Per Person**			***Lifetime* Maximum: $1,000 Per Person**
Waiting Period	12-month waiting period for Coverage C for new hires and new enrollees.			
Weekly Deductions	**Member Only $10.96 ■ Member + 1 $20.95 ■ Member + 2 or more $30.07**			

Benefit percentages shown are based on the actual charges submitted up to the Maximum Allowable Charge for participating dentists, or Delta Dental's allowance for non-participating dentists.